VISION SCREENING REFERRAL

Name ________________________________ Date ________________

School ________________________________ Grade ________________

Dear Parent/Guardian:

We have completed the vision screening service provided as part of the School Health Program. Results of your child's vision test indicate the need for an eye examination by an Eye Care Specialist. *Please note: Failure of the Color Vision Test does not require an eye examination. The findings of the school vision-screening test are recorded below:

FINDINGS: SCHOOL VISION SCREENING TESTS

1. Visual Acuity: FAR

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<th>Right/Left</th>
<th>With glasses:</th>
<th>Passed</th>
<th>Failed</th>
<th>Right/Left</th>
<th>Passed</th>
<th>Failed</th>
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2. Convex Lens (excessive farsightedness): Passed Failed Not Tested

3. Color Vision: Passed Failed Not Tested

*Eye exam not required

4. Stereo/Depth Perception: Passed Failed Not Tested

Comments:

_____________________________________________________________________________________

Since uncorrected vision disorders can affect learning potential, it is important to have your child’s Eye Care Specialist complete the form on the back of this letter and return it to the school.

Thank you for your cooperation. If you have any questions or I can be of assistance, please contact me.

School Nurse/Practitioner ________________________________ Telephone Number ________________________________
SCHOOL HEALTH PROGRAM

EYE SPECIALIST REPORT

Name_________________________ Grade ___ Date__________

Visual Acuity:

FAR

Without correction: Right/Left Right/Left

With correction:

FAR

Without correction: Right/Left Right/Left

Diagnosis or explanation of eye condition:

________________________________________

________________________________________

Plan of Treatment:

Glasses Prescribed Yes___ No___

Constant Wear Yes___ No___

Near Work Only Yes___ No___

Distance Work Only Yes___ No___

Contact(s) Prescribed Yes___ No___

Recommendation for school:

________________________________________

________________________________________

Return visit: ______________________________

(Return report to School Nurse)

Print Name of Eye Care Specialist
________________________________________

Signature of Eye Care Specialist
________________________________________

Telephone Number _____________________________________________